Complete Summary

TITLE

Cholesterol management for patients with cardiovascular conditions: percentage of patients with a cardiovascular condition who had a low-density lipoprotein cholesterol (LDL-C) screening performed and the percentage of patients who have a documented LDL-C level less than 100 mg/dL.

SOURCE(S)

National Committee for Quality Assurance (NCQA). HEDIS® 2010: Healthcare Effectiveness Data & Information Set. Vol. 1, Narrative. Washington (DC): National Committee for Quality Assurance (NCQA); 2009 Jul. 90 p.

National Committee for Quality Assurance (NCQA). HEDIS® 2010: Healthcare Effectiveness Data & Information Set. Vol. 2, Technical Specifications. Washington (DC): National Committee for Quality Assurance (NCQA); 2009 Jul. 417 p.

Measure Domain

PRIMARY MEASURE DOMAIN

Outcome

The validity of measures depends on how they are built. By examining the key building blocks of a measure, you can assess its validity for your purpose. For more information, visit the Measure Validity page.

SECONDARY MEASURE DOMAIN

Process

Brief Abstract

DESCRIPTION

This measure is used to assess the percentage of members 18 through 75 years of age who were discharged alive for acute myocardial infarction (AMI), coronary artery bypass graft (CABG), or percutaneous transluminal coronary angioplasty (PTCA) from January 1 through November 1 of the year prior to the measurement year, *or* who had a diagnosis of ischemic vascular disease (IVD) during the measurement year or year prior to the measurement year, who had each of the following during the measurement year:

- LDL-C screening performed
- LDL-C controlled (less than 100 mg/dL)

Note from the National Quality Measures Clearinghouse (NQMC): For this measure, there are both Administrative and Hybrid Specifications. This NQMC measure summary is based on the Administrative Specification. Refer to the original measure documentation for details pertaining to the Hybrid Specification.

RATIONALE

Total blood cholesterol is directly related to the development of coronary artery disease (CAD) and coronary heart disease (CHD), with most of the risk being associated with low-density lipoprotein cholesterol (LDL-C). When LDL-C levels are high, cholesterol can build up within the walls of the arteries, causing atherosclerosis, the build-up of plaque. Hemorrhaging or clot formation can occur at the site of plaque build-up, blocking arteries and causing heart attack and stroke.

Reducing cholesterol in patients with known heart disease is critically important, as treatment can reduce morbidity (heart attack and stroke) and mortality by as much as 40%. The National Cholesterol Education Program (NCEP) has established guidelines for managing cholesterol levels in patients with heart disease. Â The guidelines established the need for close monitoring of LDL cholesterol in patients with coronary heart disease and set a target for LDL-C of less than or equal to 100 mg/dL for such patients.

Cholesterol screening and control depends on the combined efforts of patient, physician and organization. Lifestyle factors and new medications offer tangible means for reducing cholesterol and the risk of heart disease.

PRIMARY CLINICAL COMPONENT

Acute myocardial infarction (AMI); coronary artery bypass graft (CABG); percutaneous transluminal coronary angioplasty (PTCA); ischemic vascular disease (IVD); low-density lipoprotein cholesterol (LDL-C); screening

DENOMINATOR DESCRIPTION

Members age 18 through 75 years who were discharged alive for acute myocardial infarction (AMI), coronary artery bypass graft (CABG), or percutaneous transluminal coronary angioplasty (PTCA) from January 1 through November 1 of the year prior to the measurement year, *or* who had a diagnosis of ischemic vascular disease (IVD) during measurement year or year prior to the measurement year (see the "Description of Case Finding" and the "Denominator Inclusions/Exclusions" fields in the Complete Summary)

NUMERATOR DESCRIPTION

Low-density Lipoprotein Cholesterol (LDL-C) Screening: An LDL-C test performed any time during the measurement year

LDL-C Level Less Than 100 mg/dL: The most recent LDL-C level during the measurement year is less than 100 mg/dL

See the related "Numerator Inclusions/Exclusions" field in the Complete Summary.

Evidence Supporting the Measure

EVIDENCE SUPPORTING THE CRITERION OF QUALITY

- A clinical practice guideline or other peer-reviewed synthesis of the clinical evidence
- A formal consensus procedure involving experts in relevant clinical, methodological, and organizational sciences
- One or more research studies published in a National Library of Medicine (NLM) indexed, peer-reviewed journal

Evidence Supporting Need for the Measure

NEED FOR THE MEASURE

Overall poor quality for the performance measured
Use of this measure to improve performance
Variation in quality for the performance measured

EVIDENCE SUPPORTING NEED FOR THE MEASURE

National Committee for Quality Assurance (NCQA). The state of health care quality 2009. Washington (DC): National Committee for Quality Assurance (NCQA); 2009. 127 p.

Third Report of the National Cholesterol Education Program (NCEP) Expert Panel on Detection, Evaluation, and Treatment of High Blood Cholesterol in Adults (Adult Treatment Panel III) final report. Circulation2002 Dec 17;106(25):3143-421. PubMed

State of Use of the Measure

STATE OF USE

Current routine use

CURRENT USE

Accreditation
Decision-making by businesses about health-plan purchasing
Decision-making by consumers about health plan/provider choice
External oversight/Medicaid
External oversight/Medicare

External oversight/State government program
Internal quality improvement

Application of Measure in its Current Use

CARE SETTING

Managed Care Plans

PROFESSIONALS RESPONSIBLE FOR HEALTH CARE

Measure is not provider specific

LOWEST LEVEL OF HEALTH CARE DELIVERY ADDRESSED

Single Health Care Delivery Organizations

TARGET POPULATION AGE

Age 18 through 75 years

TARGET POPULATION GENDER

Either male or female

STRATIFICATION BY VULNERABLE POPULATIONS

Unspecified

Characteristics of the Primary Clinical Component

INCIDENCE/PREVALENCE

One in three American adults have some form of cardiovascular disease, including coronary heart disease, high blood pressure, heart failure and stroke.

EVIDENCE FOR INCIDENCE/PREVALENCE

American Heart Association. Heart disease and stroke statistics - 2008 update. Dallas (TX): American Heart Association; 2008. 43 p.

ASSOCIATION WITH VULNERABLE POPULATIONS

Unspecified

BURDEN OF ILLNESS

Coronary heart disease claims over 450,000 lives annually and continues to be the number one killer in the United States. High cholesterol is a major risk factor for and cause of cardiovascular disease.

EVIDENCE FOR BURDEN OF ILLNESS

American Heart Association. Heart Disease and Stroke Statistics - 2008 Update. A Report from the American Heart Association Statistics Committee and Stroke Statistics Subcommittee. [internet]. 2008 Feb

Centers for Disease Control and Prevention (CDC). Heart disease. [internet]. Atlanta (GA): Centers for Disease Control and Prevention (CDC); 2007 Nov 15[accessed 2008 Feb 28].

UTILIZATION

Unspecified

COSTS

In 2009, heart disease is projected to cost more than $304.6 billion, including health care services, medications and lost productivity.

EVIDENCE FOR COSTS

Centers for Disease Control and Prevention (CDC). Heart disease facts and statistics. [internet]. Atlanta (GA): National Center for Chronic Disease Prevention and Health Promotion, Division for Heart Disease and Stroke Prevention; [updated 2009 Dec 07]; [accessed 2010 Jan 22].

Institute of Medicine National Healthcare Quality Report Categories

IOM CARE NEED

Living with Illness

IOM DOMAIN

Effectiveness

Data Collection for the Measure

CASE FINDING

Users of care only

DESCRIPTION OF CASE FINDING

Members age 18 through 75 years as of December 31 of the measurement year who were discharged alive for acute myocardial infarction (AMI), coronary artery bypass graft (CABG), or percutaneous transluminal coronary angioplasty (PTCA) from January 1 through November 1 of the year prior to the measurement year, *or* who had a diagnosis of ischemic vascular disease (IVD) during the measurement year or year prior to the measurement year and who were continuously enrolled during the measurement year and the year prior to the measurement year with no more than one gap in enrollment of up to 45 days during each year of continuous enrollment (commercial, Medicare) or with not more than a one-month gap in coverage (Medicaid).

DENOMINATOR SAMPLING FRAME

Patients associated with provider

DENOMINATOR INCLUSIONS/EXCLUSIONS

Inclusions
Members age 18 through 75 years who were discharged alive for acute myocardial infarction (AMI)*, coronary artery bypass graft (CABG)*, or percutaneous transluminal coronary angioplasty (PTCA)** from January 1 through November 1 of the year prior to the measurement year, *or* who had a diagnosis of ischemic vascular disease (IVD)*** during the measurement year or year prior to the measurement year

*AMI and CABG cases should be from inpatient claims/encounters only.

**All cases of PTCA should be included regardless of setting (e.g., inpatient, outpatient, emergency department [ED]).

***At least one outpatient visit *or* one acute inpatient claim/encounter with any diagnosis of IVD.

Refer to the original measure documentation for administrative codes to identify AMI, PTCA, CABG, and IVD.

Exclusions
Unspecified

RELATIONSHIP OF DENOMINATOR TO NUMERATOR

All cases in the denominator are equally eligible to appear in the numerator

DENOMINATOR (INDEX) EVENT

Clinical Condition
Diagnostic Evaluation
Encounter
Institutionalization
Therapeutic Intervention

DENOMINATOR TIME WINDOW

Time window precedes index event

NUMERATOR INCLUSIONS/EXCLUSIONS

Inclusions

Low-density Lipoprotein Cholesterol (LDL-C) Screening: An LDL-C test performed any time during the measurement year, as identified by claim/encounter or automated laboratory data. Refer to Table CMC-D in the original measure documentation for administrative codes to identify LDL-C screening.

LDL-C Level Less Than 100 mg/dL: The most recent LDL-C level during the measurement year is less than 100 mg/dL, as identified by automated laboratory data or Current Procedure Terminology (CPT) II Category II codes.

Exclusions

The member is noncompliant if the automated result for the most recent LDL-C test is greater than or equal to 100 mg/dL or is missing, or if an LDL-C test was not done during the measurement year.

MEASURE RESULTS UNDER CONTROL OF HEALTH CARE PROFESSIONALS, ORGANIZATIONS AND/OR POLICYMAKERS

The measure results are somewhat or substantially under the control of the health care professionals, organizations and/or policymakers to whom the measure applies.

NUMERATOR TIME WINDOW

Fixed time period

DATA SOURCE

Administrative data
Laboratory data
Medical record

LEVEL OF DETERMINATION OF QUALITY

Not Individual Case

OUTCOME TYPE

Clinical Outcome

PRE-EXISTING INSTRUMENT USED

Unspecified

Computation of the Measure

SCORING

Rate

INTERPRETATION OF SCORE

Better quality is associated with a higher score

ALLOWANCE FOR PATIENT FACTORS

Analysis by subgroup (stratification on patient factors, geographic factors, etc.)

DESCRIPTION OF ALLOWANCE FOR PATIENT FACTORS

This measure requires that separate rates be reported for commercial, Medicare, and Medicaid plans.

STANDARD OF COMPARISON

External comparison at a point in time
External comparison of time trends
Internal time comparison

Evaluation of Measure Properties

EXTENT OF MEASURE TESTING

Unspecified

Identifying Information

ORIGINAL TITLE

Cholesterol management for patients with cardiovascular conditions (CMC).

MEASURE COLLECTION

HEDIS® 2010: Health Plan Employer Data and Information Set

MEASURE SET NAME

Effectiveness of Care

MEASURE SUBSET NAME

Cardiovascular Conditions

DEVELOPER

National Committee for Quality Assurance

FUNDING SOURCE(S)

Unspecified

COMPOSITION OF THE GROUP THAT DEVELOPED THE MEASURE

National Committee for Quality Assurance's (NCQA's) Measurement Advisory Panels (MAPs) are composed of clinical and research experts with an understanding of quality performance measurement in the particular clinical content areas.

FINANCIAL DISCLOSURES/OTHER POTENTIAL CONFLICTS OF INTEREST

In order to fulfill National Committee for Quality Assurance's (NCQA's) mission and vision of improving health care quality through measurement, transparency and accountability, all participants in NCQA's expert panels are required to disclose potential conflicts of interest prior to their participation. The goal of this Conflict Policy is to ensure that decisions which impact development of NCQA's products and services are made as objectively as possible, without improper bias or influence.

ADAPTATION

Measure was not adapted from another source.

RELEASE DATE

1999 Jan

REVISION DATE

2009 Jul

MEASURE STATUS

This is the current release of the measure.

This measure updates a previous version: National Committee for Quality Assurance (NCQA). HEDIS® 2009: Healthcare Effectiveness Data & Information Set. Vol. 2, Technical Specifications. Washington (DC): National Committee for Quality Assurance (NCQA); 2008 Jul. various p.

SOURCE(S)

National Committee for Quality Assurance (NCQA). HEDIS® 2010: Healthcare Effectiveness Data & Information Set. Vol. 1, Narrative. Washington (DC): National Committee for Quality Assurance (NCQA); 2009 Jul. 90 p.

National Committee for Quality Assurance (NCQA). HEDIS® 2010: Healthcare Effectiveness Data & Information Set. Vol. 2, Technical Specifications. Washington (DC): National Committee for Quality Assurance (NCQA); 2009 Jul. 417 p.

MEASURE AVAILABILITY

The individual measure, "Cholesterol Management for Patients with Cardiovascular Conditions (CMC)," is published in "HEDIS® 2010. Healthcare Effectiveness Data & Information Set. Vol. 2, Technical Specifications."

For more information, contact the National Committee for Quality Assurance (NCQA) at 1100 13th Street, NW, Suite 1000, Washington, DC 20005; Telephone: 202-955-3500; Fax: 202-955-3599; Web site: www.ncqa.org.

COMPANION DOCUMENTS

The following is available:

- National Committee for Quality Assurance (NCQA). The state of health care quality 2009. Washington (DC): National Committee for Quality Assurance (NCQA); 2009. 127 p.

For more information, contact the National Committee for Quality Assurance (NCQA) at 1100 13th Street, NW, Suite 1000, Washington, DC 20005; Telephone: 202-955-3500; Fax: 202-955-3599; Web site: www.ncqa.org.

NQMC STATUS

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